

Page 4
The low requires that the death certificate be executed within 72 hours after death.
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5472

CERTIFICATE OF DEATH

Reg. Dist. No.

05466

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Unknown			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS Patuxent River		c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEANSBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS Patuxent River, Maryland				d. STREET ADDRESS 416 Carr Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Edward ANDERSON				4. DATE OF DEATH Month May Day 4 Year 56			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-34	
9. AGE (In years lost birthday) 21 yrs.		IF UNDER 1 YEAR Months 4 Days 19		IF UNDER 24 HRS. Hours 56 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY U. S. NAVY		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Alex ANDERSON				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 12/7/53 to		17. INFORMANT U. S. Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Depressed Skull Fracture 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 823X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, lost control of car, struck pole.			
20c. TIME OF INJURY Month, Day, Year 5:20 a.m. 5 4 19 56				20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 235	
20f. (City or town) Mechanicsville, St. Mary's				20g. (County) St. Mary's		20h. (State) Maryland	
21. I certify that I attended the deceased from 4 May , 19 56 , to 4 May , 19 56 , that I last saw the deceased alive on 4 May , 19 56 , and that death occurred at 6:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. G. Pomponio				M.D. Station Hospital, U.S. Naval Air Station, Patuxent River, Maryland			
PHYSICIAN'S NAME (Type) J. G. POMPONIO, LT MC USNR				4 May 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 4/5/56		22c. NAME OF CEMETERY OR CREMATORY Leonardtown, Md.		22d. LOCATION (City, town, or county) (State) Keansburg, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson				24a. REC'D BY REGISTRAR DATE 5/7/56		24b. REGISTRAR'S SIGNATURE Alan D. ...	

MAY 9 1956

TO HOPE FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05467

5473

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oraville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS • IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Harry Last Buckler		4. DATE OF DEATH Month May Day 8 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard O. Buckler		14. MOTHER'S MAIDEN NAME Rebecca Dean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bernard T. Buckler		Address Oraville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. disease with auric fibrillation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric ulcer - possibly malignant		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar , 19 50 , to May 8 , 19 56 , that I last saw the deceased alive on May 8 , 19 56 , and that death occurred at HA M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md 5756 DATE SIGNED ACTUAL SIGNATURE J. Roy Guyther M.D. J. Roy Guyther PHYSICIAN'S NAME (Type) J. Roy Guyther M. D. Mechanicsville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-56	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Mottersley Leonardtown, Md		24a. REC'D BY REGISTRAR DATE 5/10/56	
24b. REGISTRAR'S SIGNATURE Alan D. L...			

MAY 11 1956

RECEIVED
MAY 11 1956

D5PL 5474TE

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>ST MARY'S</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ST MARY'S</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Lexington Park</u>		<u>5 years</u>		TOWN <u>LEXINGTON PARK</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u># 2 Banks Place</u>				STREET ADDRESS <u>2 BANKS PLACE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>ADMIRAL DEWEY COLEY</u>				<u>MAY 14 1956</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>MALE</u>		<u>WHITE</u>		<u>MARRIED</u>		<u>AUG. 16, 1899</u>	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>56 yrs.</u>		<u>8 Months</u>		<u>29 Days</u>		<u>Hours</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, or of regular occupation				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>HEAVY DUTY MECHANIC U.S. NAVY</u>				<u>U.S. NAVY</u>		<u>NORTH CAROLINA U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>EDWARD B. COLEY</u>				<u>MRS FLOESSIE COLEY, 2 BANKS PLACE, LEXINGTON PARK, MD.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>NONE</u>		<u>229-12-9950</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>420.1</u>						<u>2 HOURS</u>	
Immediate cause (a) <u>CORONARY OCCLUSION</u>							
Antecedent causes (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 14, 1956</u> , to <u>MAY 14, 1956</u> that I last saw the deceased alive on <u>MAY 14, 1956</u> and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>P. J. Beary M.D.</u>				ADDRESS <u>LEXINGTON PARK, MD.</u>			
DATE SIGNED <u>5-17-1956</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-17-1956</u>		<u>ONTARIO CHRISTIAN</u>		<u>KEYSVILLE VA.</u>	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-15-56</u>		<u>P. J. Beary M.D.</u>		<u>CHARLES J. MATTINGLY</u>		<u>LEXINGTON PARK, MD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUN 1 1956

RECEIVED

1
death: Page 4
TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.
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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5475
CERTIFICATE OF DEATH

05469
287
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WYNN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL				d. STREET ADDRESS RURAL			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last SARAH RUSSELL CULLISON				4. DATE OF DEATH Month Day Year MAY 19 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 1, 1891	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES R. LEWIS		14. MOTHER'S MAIDEN NAME ALICE DOBBINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address JOHN HERBERT CULLISON- WYNN, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Coronary sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1957 , to May 19, 1956 , that I last saw the deceased alive on May 18, 1956 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Opinion M.D. Great Mills Md 5/19/56							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Opinion							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/21/56		22c. NAME OF CEMETERY OR CREMATORY TRINITY EPISCOPAL		22d. LOCATION (City, town, or county) (State) ST. MARYS CITY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Spinson				ADDRESS - LEONARDTOWN, Md.		24a. REC'D BY REGISTRAR DATE 5/19/56	
				24b. REGISTRAR'S SIGNATURE Local Registrar			

5476

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARY'S				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE First ELLERBROOK Middle LEONARDTOWN Last MARYLAND				4. DATE OF DEATH Month MAY Day 10 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5 1880	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 3 Days 5 Hours 5 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRIC INSPECTOR				10b. KIND OF BUSINESS OR INDUSTRY SUPERINTENDENT WASHINGTON, D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-07-8022		17. INFORMANT RUTH ELLERBROOK BUSHWOOD MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. dis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 1/2 D							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar 10, 1950 , to May 10, 1956 , that I last saw the deceased alive on May 9, 1956 , and that death occurred at 10:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicville, Md. DATE SIGNED ACTUAL SIGNATURE J. Roy Guyther M.D. PHYSICIAN'S NAME (Type) J. ROY GUYTHER M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/13/1956		22c. NAME OF CEMETERY OR CREMATORY ALL SAINTS		22d. LOCATION (City, town, or county) (State) OAKLEY MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES J. MATTINGLY				ADDRESS LEONARDTOWN MD.		24a. REC'D BY REGISTRAR DATE 5/11/56	
				24b. REGISTRAR'S SIGNATURE Alan D. Hunsman			

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

BUREAU V. 3

MAY 14 1956

RECEIVED

Item 18 Film G198 5-28-56 ams

5477

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 36 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) ST. MARY'S HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Elizabeth Johnson				4. DATE OF DEATH Month Day Year MAY 16, 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1898	9. AGE (In years last birthday) yrs. 57	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 8 8		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Philip C. MAUDER DRURY				14. MOTHER'S MAIDEN NAME Mary Lucy Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mattingly Johnson Clements, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombophlebitis, left lower extremity DUE TO (c) Cancer, colon, ascending							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4. 8. 56 19, to 5. 16. 56 19, that I last saw the deceased alive on 5. 16. 56 19, and that death occurred at 10:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Michael Barbarich M.D.							
PHYSICIAN'S NAME (Type) Micahel Barbarich M.D. Leonardtown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 5/18/56		24b. REGISTRAR'S SIGNATURE Alan R. [Signature]	

1

Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

BUREAU V. S.

MAY 21 1956

RECEIVED

Michael G. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5478 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05472

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>ST. MARY'S</u> <u>HERMANSVILLE MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HERMANSVILLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (If known) <u>JOSEPH MELVIN</u> First <u>LEE</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3, 1930</u> 26 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u>	11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>
13. FATHER'S NAME <u>Joseph J. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Helen Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1951-1953</u>		17. INFORMANT <u>Helen Taylor</u> Address <u>703-64th St. Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE GUNSHOT WOUNDS OF</u> <u>981X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHEST & ABDOMEN</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5-6</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>TAVERN</u>		20f. (City or town) (County) (State) <u>HERMANSVILLE-ST. MARY'S-MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Russell S Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S Fisher</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-9-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Graham - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/7/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Glenn D. Hume, Jr.</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 9 1956
BUREAU V.

MAY 9 1956

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Md.		b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Lillie May		Middle Nichols		Last Nichols	
4. DATE OF DEATH May 24, 1956		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov 14, 1870		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Thomas		14. MOTHER'S MAIDEN NAME Regina Tundle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT R.E. Taylor		Address Bushwood, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2hemiz (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept., 1955 , to 24 May, 1956 , that I last saw the deceased alive on 21 May, 1956 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Leon A Beruke M.D. Mechanicsville, Md		DATE SIGNED 5/24/56			
ACTUAL SIGNATURE Leon A Beruke		PHYSICIAN'S NAME (Type) Leon Beruke		22a. BURIAL, CREMATION, REMOVAL (Specify) 5/26/56		22b. DATE THEREOF Point of Rocks Cem.	
22c. NAME OF CEMETERY OR CREMATORY Point of Rocks Cem.		22d. LOCATION (City, town, or county) (State) Point of Rocks, Md		23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR 5/29/56	
24b. REGISTRAR'S SIGNATURE Alan D. Hines		DATE 5/29/56					

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. MARITAL STATUS		7. CAUSE OF DEATH		8. MANNER OF DEATH	
Home		Male		45		White		Teacher		Married		Heart Disease		Natural	
10. DATE OF DEATH		11. TIME OF DEATH		12. PLACE OF BURIAL		13. NAME OF BURIAL PLACE		14. NAME OF MINISTER		15. NAME OF FUNERAL HOME		16. NAME OF CARRIER		17. NAME OF UNDERTAKER	
June 1, 1956		10:00 AM		Catholics		St. Mary's		Rev. J. J. Smith		John Doe		John Doe		John Doe	
18. SIGNATURE OF DECEASED		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF MINISTER		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CARRIER		23. SIGNATURE OF UNDERTAKER		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF CORONER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. B.

JUN 1 1956

RECEIVED

5480

CERTIFICATE OF DEATH

05474

Reg. Dist. No. 282

1. PLACE OF DEATH o. COUNTY St Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b 12 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Mary's Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			
				d. STREET ADDRESS Lexington Park			
3. NAME OF DECEASED (Type or print) First Lillian Middle Ann Last Smith				4. DATE OF DEATH Month May Day 18 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1936	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months 2 Days 3	IF UNDER 24 HRS. Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Elmer Goddard				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212 34 6741			
				17. INFORMANT Francis H. Smith Address Ridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 467.0 Hypotension DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/17/56 , 19____, to 5/18/56 , 19____, that I last saw the deceased alive on 5/18/56 , 19____, and that death occurred at 7 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lexington Park DATE SIGNED mid 5/18/56							
ACTUAL SIGNATURE Julian S. Lane M.D.				DATE SIGNED mid 5/18/56			
PHYSICIAN'S NAME (Type) JULIAN S. LANE M.D.				317 Great Mills Road Lexington Park Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 21, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Micheal		22d. LOCATION (City, town, or county) (State) Ridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE 5/21/56	
				24b. REGISTRAR'S SIGNATURE Alan D. [Signature]			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

MAY 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5481

CERTIFICATE OF DEATH

05475

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>California</u> b. COUNTY <u>Orange</u>			
X b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Station Hospital, USNAS, Patuxent River, Maryland</u>				d. STREET ADDRESS <u>354 Stevens St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Joseph</u> Last <u>SPIERS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 March 1918</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Marine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Marine</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1939-1956</u>		17. INFORMANT <u>U.S. Navy Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Thrombosis, Coronary Artery (4702)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 May</u> , 19 <u>56</u> , to <u>1 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1 May</u> , 19 <u>56</u> , and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>R. D. Nauman</u>				M.D. <u>Station Hospital, U.S. Naval Air Station</u>			
PHYSICIAN'S NAME (Type) <u>R. D. NAUMAN, CDR, MC, USN</u>				<u>Patuxent River, Maryland</u> <u>1 May 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>5/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leonardtawn, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Bogalusa, Louisiana.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u>				24a. REC'D BY REGISTRAR DATE <u>5/7/56</u>		24b. REGISTRAR'S SIGNATURE <u>Alan P. ...</u>	

MEDICAL CERTIFICATION

TO HOST: The low requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5432

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clements				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Earl First James Middle Vallandingham Last				4. DATE OF DEATH May Month 7 Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 May 26, 1938	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Vallandingham				14. MOTHER'S MAIDEN NAME Mary Eva Guy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Mrs Elizabeth C. Vallandingham Clements, Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Subarachnoid Hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 May, 1956 , to 7 May, 1956 , that I last saw the deceased alive on May 23, 1956 , and that death occurred at 2:21 M. from the causes and on the date stated above. ACTUAL SIGNATURE ROY CUYTHER M.D. Indianapolis, Ind DATE SIGNED PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 9, 1956		22c. NAME OF CEMETERY OR CREMATORY St Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingley Leonardtwn, Md.				24a. REC'D BY REGISTRAR DATE 5/8/56		24b. REGISTRAR'S SIGNATURE Alfred D. Vallandingham	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
James William		Male		35		May 28, 1920		Maryland	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
Married		May 28, 1945		Maryland		May 28, 1956		Maryland	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
Farmer		May 28, 1956		Maryland		May 28, 1956		Maryland	
CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
Heart Disease		May 28, 1956		Maryland		May 28, 1956		Maryland	
MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
Natural		May 28, 1956		Maryland		May 28, 1956		Maryland	
SIGNATURE OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
J. William		May 28, 1956		Maryland		May 28, 1956		Maryland	
SIGNATURE OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
J. William		May 28, 1956		Maryland		May 28, 1956		Maryland	

BUREAU A. 3

MAY 9 1956

RECEIVED